

Your Unit's Letterhead

XXX-X-X

{Today's Date}

MEMORANDUM TO: OIC, Refractive Surgery Center,

SUBJECT: Battalion Commander's Endorsement for Refractive Eye Surgery

1. **{Service Member's Name & SSN}** has my permission to get refractive eye surgery at _____.
2. **Deployment**
 - a. This service member will likely deploy within the next 12 months: **{Please type Yes or No}**
 - b. If Yes, projected deployment date: **{Please type Earliest Probable Deployment Date; Unknown is not a valid response}**
3. This service member (SM) is **{Please type combat arms or non-combat arms}**
4. I certify that the following are true & I will inform the refractive surgery center if SM's circumstances change:
 - a. SM has at least 18 months remaining on active duty
 - b. SM has no adverse personnel actions pending
 - c. SM will remain CONUS for at least 90 days after surgery
 - d. SM is not scheduled to PCS in the next 6 months
 - e. SM is at least 21 years of age
 - f. SM is NOT going through or considered for Medical Evaluation Board (MEB).
5. I realize that after surgery the SM will have convalescent leave until his/her follow up appointment 7 days after surgery. In addition, I understand that the SM will have the following profile for a minimum of 30 days & agree to abide by this profile:
 - a. No field duty or driving military vehicles
 - b. No organized PT, but SM may do modified individual PT
 - c. No Airborne/SCUBA/tactical/night operations
 - d. No swimming, protective mask wear, or use of camouflage face paint
 - e. Must wear sunglasses when outdoors sunrise to sundown for 60 days; may wear sunglasses at all times if desired.
6. I will ensure the SM makes all follow-up appointments with the Refractive Surgery Center to avoid potential complications.
 - a. These appointments are usually scheduled 1, 6, 30, 60, 90 & 180 days after surgery.
 - b. I will ensure the service member has transportation to these appointments in the event he/she cannot drive him/herself.
7. I further realize that the service member must remain in CONUS for at least 90 days following the surgery.
8. I will notify the Refractive Surgery Center immediately if the soldier's circumstances change & he/she no longer meets the above criteria.
9. This authorization is good for six (6) months. If surgery is scheduled more than six (6) months from this memo's date, a new commander's endorsement must be completed before surgery.

Company CDR's Signature

**{Please Type Signature Block
to include Name, Rank,
Branch & Unit}**

{Type CO CDR's Phone Number}

Phone Number

Date Signed

{Type CO CDR's E-mail Address}

Company CDR's E-mail Address

Battalion CDR's Signature

**{Please Type Signature Block
to include Name, Rank,
Branch & Unit}**

{Type BN CDR's Phone Number}

*Phone Number
Signed*

Date

{Type BN CDR's E-mail Address}

Battalion CDR's E-mail Address